

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/01/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155106		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 05/12/2011	
NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD ROAD NOBLESVILLE, IN46060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	<p>This visit was for the Investigation of Complaints IN00089250 and IN00089728.</p> <p>Complaint IN00089250 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00089728 - Substantiated, state deficiency related to the allegation is cited at F9999.</p> <p>Survey dates: May 11, 12, 2011</p> <p>Facility number: 000044 Provider number: 155106 AIM number: 100274940</p> <p>Surveyor: Jeri Curtis, RN</p> <p>Census bed type: SNF/NF: 146 Total: 146</p> <p>Census payor type: Medicare: 19 Medicaid: 104 Other: 23 Total: 146</p> <p>Sample: 4</p> <p>Riverwalk Village was found to be in</p>			F0000	<p>The Creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulationThis Provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a Desk Review in lieu of a Post Survey review on or after May15, 2011.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155106		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 05/12/2011	
NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD ROAD NOBLESVILLE, IN46060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F9999	<p>compliance with 42 CFR Part 483, Subpart B in regard to the Investigation of Complaints IN00089250 and IN00089728. This state finding is cited in accordance with 410 IAC 16.2.</p> <p>STATE FINDINGS</p> <p>3.1-13 ADMINISTRATION AND MANAGEMENT</p> <p>The facility must operate and provide services in compliance with all applicable federal, state, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on observation, record review, and interview, the facility failed to assure 4 of 9 sharps containers were covered,</p>			F9999	<p>F9999 - It is the consistent practice of this Provider to ensure this facility operates and provides services in compliance with all applicable federal, state, and local laws, regulations, and codes and with accepted professional standards and principles that apply to professionals providing services.I. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice.No residents were affected by the alleged deficient practice. The locked and secured bio-hazard room was immediately cleaned; all sharps and sharp containers properly secured and placed in a sealed bio-hazard box and picked up by an appropriate hazard waste company.II. How other residents having the potential to be affected by the same alleged deficient practice will be identified</p>		05/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155106		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 05/12/2011	
NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD ROAD NOBLESVILLE, IN46060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>secured, and placed in the biohazard containers, resulting in spillage onto the floor</p> <p>of used sharps, used alcohol prep pads, and a quantity of pills.</p> <p>Findings include:</p> <p>During the 5/11/11, from 10:35 to 11:35 A.M., environmental tour on station 1, Licensed Practical Nurse (LPN #1) unlocked the biohazard room. Nine sharps containers (used needles) were observed on the counter top. Four of the nine containers did not have lids. The four containers were full with needles protruding from the top. Five used sharps, five opened alcohol prep pads, and a quantity of white, unidentified, pills were on the floor. A plastic hamper with a lid was observed in the room. A large cardboard box with a red plastic liner, used for infectious waste, was observed on the counter top.</p> <p>During interview at this time, LPN #1 indicated the used sharps appeared to have been spilled onto the floor from the uncovered containers. LPN #1 indicated the facility had recently stocked sharps containers which did not fit the attached holders on the medication carts. LPN #1 also indicated the lids in stock did not fit the new sharps containers. LPN #1</p>				<p>and what corrective action will be taken.No other residents have the potential to be affected by the same alleged deficient practice.III. What measures will be put into place or what systematic changes will be made to ensure that alleged deficient practice will not recur.Nursing staff were inserviced by the Director of Nursing on 5/13 and Weekend Mgr on 5/14 re: Infection control including the proper storage of sharps, sharp containers and bio-waste storage. A post test was provided to staff to evaluate and ensure understanding of the content.Non-compliance with the facility Infection control standards and policies may result in employee re-education and/or disciplinary action up to and including terminationIV. How the corrective action will be monitored to ensure the alleged deficient practice will not recur.Nursing staff completes daily rounds on each shift to monitor and ensure the facility is following proper Infection Control practices.Nursing managers complete daily rounds to monitor and ensure the facility staff are following proper Infection Control practices to include the storage of sharps, sharp containers and bio waste storage.An Infection Control CQI will be used weekly x4 and then quarterly thereafter. The governing CQI committee will review the data for any required</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/01/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155106		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 05/12/2011	
NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD ROAD NOBLESVILLE, IN46060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>indicated the sharps containers should have been placed in one of the infectious waste containers.</p> <p>The Director of Nursing (DoN) provided a copy of the Syringe Disposal policy (undated) on 5/11/11. The purpose was to ensure used syringes were disposed of in a safe manner in accordance with state and federal regulations. The procedures included: disposal of syringes according to established procedures set forth by the Center for Disease Control (CDC) and the agency for Occupational Safety and Health. Non-permeable containers were to be used for disposing of syringes. Needles were never to be recapped after use and were not to be cut from the syringe. Containers were to be picked up and destroyed by a contract disposal company that adhered to established federal guidelines for hazardous medical waste.</p> <p>This state finding relates to Complaint IN00089728.</p> <p>3.1-13(r)</p>				<p>follow up, action plan or re-education. The Director of Nursing and/or designee is responsible for ongoing monitoring. V. By what date the systematic changes will be completed. May 15, 2011</p>		